Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOHN A SAZY MD
431 ONEGA DRIVE SUITE 104
ARLINGTON TX 76014

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-1897-01

MFDR Date Received
FEBRUARY 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:

"2222: Dr. sazy performed the osteotomy and is documented in the operative report. The definition of osteotomy is cutting the bone. In this case, cutting the bone that allows for changing position of the intervening vertebra to affect a correction to the normal alignment of the spine. In this case the bone cut was the incomplete fusion through the intervertebral spce where a prosthetic intervertebral cage was inserted at C5/6. All this is in the operative procedure.

63075 & 63076: Both procedures were performed and are documented in the operative report. The insurance carrier's denial reason of 'this procedure code is not valid for this date of service' does not make any sence and is itself not valid.

22554 & 22585: Again both procedures were done and were documented in the operative report. The insurance carrier's denial reason does not make any sense at all."

Amount in Dispute: $4,777.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2011	CPT Code 22220	$2,374.53	$2,374.53
	CPT Code 63075-59	$1,018.21	$1,018.21
	CPT Code 63076	$188.77	$0.00
	CPT Code 22554-59	$941.27	$941.27
February 22, 2011	CPT Code 22585	$254.37	$254.37

TOTAL		$4,777.15	$4,588.38

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - F037-This procedure code is not valid for this date of service.
   - 17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
   - W1-Workers compensation state fee schedule adjustment.

Issues

1. Is the requestor entitled to reimbursement for CPT code 22220?
2. Is the requestor entitled to reimbursement for CPT code 63075-59?
3. Is the requestor entitled to reimbursement for CPT code 63076?
4. Is the requestor entitled to reimbursement for CPT code 22554-59?
5. Is the requestor entitled to reimbursement for CPT code 22585?

Findings

1. CPT code 22220 is defined as "Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical."

   A review of the Operative report indicates that the claimant underwent "osteotomy at C5-C6 with removal of cage."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2011 DWC conversion factor for this service is 68.47.

   The Medicare Conversion Factor is 33.9764

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 76104, which is located in Tarrant County.

The Medicare participating amount for code 22220 in Tarrant County is $1,583.02.

Using the above formula, the MAR is $3,190.14.

The respondent paid $0.00. The requestor is seeking $2,374.53, this amount is recommended for reimbursement.

2. CPT code 63075-59 is defined as "Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace."

   According to the National Correct Coding Initiatives (NCCI) Edits, CPT code 63075 is a component of code 22220.

   A review of the operative report indicates that the claimant underwent diskectomies at C5-6 and C6-7. Therefore, the discectomy at C5-6 is included with code 22220; however, the discectomy at C6-7 is not included. The requestor used modifier 59 to differentiate code 63075 from 22220.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   The Medicare participating amount for code 63075 in Tarrant County is $1,357.61.

   CPT code 63075 is subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $1,367.94.

   The respondent paid $0.00. The requestor is seeking $1,018.21, this amount is recommended for reimbursement.

3. CPT code 63076 is defined as "Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)."

   The Operative report does not support discectomy was performed at three levels; therefore, reimbursement is not recommended.

4. CPT code 22554 is defined as "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2."

   A review of the Operative report indicates that "a tricortical graft was contoured to fit this spce precisely and impacted into position. A 3 level plate was selected and placed over the certebrae from C4 to C7."

   The Medicare participating amount for code 22554 in Tarrant County is $1,255.02.

   CPT code 22554 is subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $1,264.57.

   The respondent paid $0.00. The requestor is seeking $941.27, this amount is recommended for reimbursement.

5. CPT code 22585 is defined as "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)."

   The Operative report supports a two level fusion; therefore, the documentation supports the additional level.

   The Medicare participating amount for code 22585 in Tarrant County is $339.16.

   CPT code 22585 is not subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $683.48.

   The respondent paid $0.00. The requestor is seeking $254.37, this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,588.38.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,588.38 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		7/8/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.